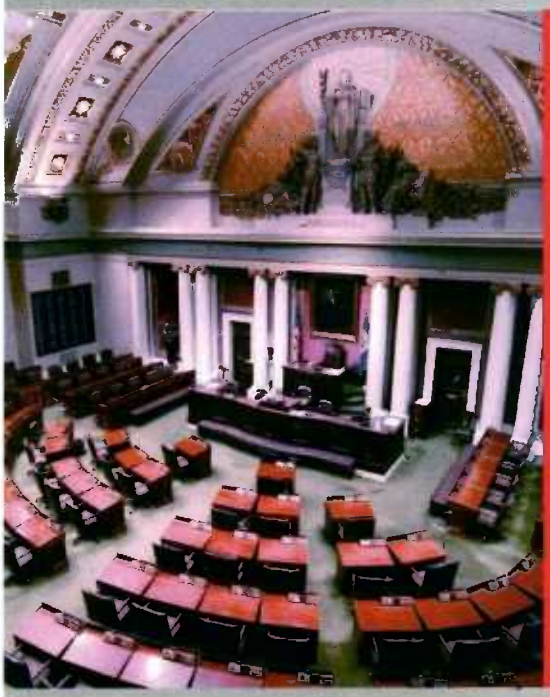

KHPAC

Kentucky HIV/AIDS Planning and Advisory Council

2012-2013 Annual Report

to the Commonwealth of Kentucky General Assembly,
the Interim Joint Committee on Health and Welfare
and the Cabinet for Health and Family Services

KENTUCKY HIV/AIDS
PLANNING & ADVISORY COUNCIL
275 East Main Street, HS2E-C
Frankfort, KY 40621-0001

October 31, 2013

Ms. Marcia Seiler
Legislative Research Commission
Room 300, Capitol Building
700 Capitol Avenue
Frankfort, KY 40601

Dear Ms. Seiler:

The Kentucky HIV/AIDS Planning and Advisory Council is pleased to present its 2012-2013 Annual Report. The Council has identified three critical priorities, which have the potential to prevent the spread of HIV/AIDS in the state of Kentucky, increase access to care, and provide cost saving measures for the Commonwealth.

Pursuant to KRS 214.640, we present this report, dated August 30, 2013, to the Kentucky General Assembly, the Interim Joint Committee on Health and Welfare, and the Cabinet for Health and Family Services.

Thank you for your attention to this report.

Sincerely,

Mark J. Royse
Community Co-Chair

Gayle Yocum
Commonwealth Co-Chair

cc: Audrey Tayse Haynes, Secretary, Cabinet for Health and Family Services
Dee Ann Mansfield, Committee Staff Administrator
Interim Joint Committee on Health and Welfare

Introduction & Table of Contents

The Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) *represents the voices of Kentucky families living with HIV/AIDS and the men and women who serve them.*

We have identified the following urgent priorities, which we hope you will consider carefully. In this report, we have attempted to present recommendations to stop the spread of HIV/AIDS in Kentucky, to improve access to care for those living with the disease, and to realize important cost savings for the Commonwealth of Kentucky.

Thank you for your time and consideration.

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Needle Decriminalization
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KHPAC Recommends:

- Statewide decriminalization of needles whether used for medical or recreational drug injection purposes (Please reference KRS 217.177; KRS 218A.500 & KRS 510)
- Readily available drug treatment services to assist those with substance abuse problems rather than jail time for lower level misdemeanor offenses.
- Support clean needle exchange programs throughout the Commonwealth especially in counties where injection drug abuse is highest.

Priority Two:
HIV Testing for Pregnant Women
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KHPAC Recommends:

- Kentucky should establish a legal mandate requiring that all pregnant women receiving care in the Commonwealth be offered HIV testing and counseling, regardless of perceived risk, as part of routine pre-natal care.

Priority Three:
Comprehensive Sexuality Education
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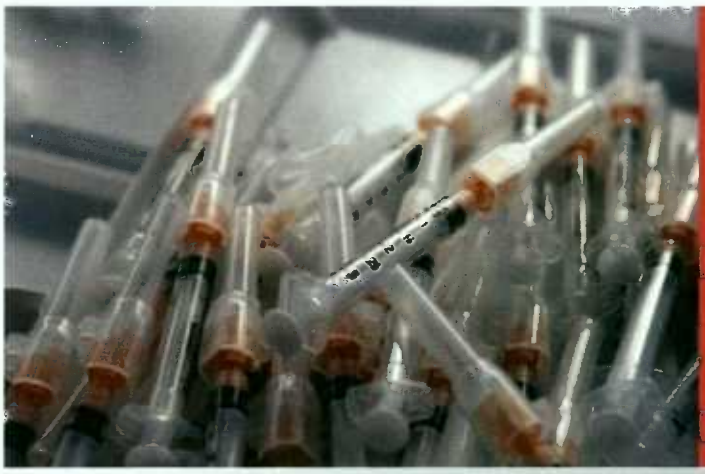
KHPAC Recommends:

- Kentucky should require that comprehensive sexuality education be provided in all public middle and high schools in Kentucky, as identified in the Program of Studies (2006) using evidence-based resources.
- Kentucky should also develop a process to ensure all middle and high school students receive this education as required by law.
- Kentucky should continue to access funding under the Personal Responsibility Education Program (PREP), which provides federal dollars for comprehensive sexuality education programs and has no state matching requirement.



Priority One: Needle Decriminalization

KHPAC RECOMMENDS:

- Statewide decriminalization of needles whether used for medical or recreational drug injection purposes (Please reference KRS 217.177; KRS 218A.500 & KRS 218.A510)
- Readily available drug treatment services to assist those with substance abuse problems rather than jail time for lower level misdemeanor offenses.
- Support clean needle exchange programs throughout the Commonwealth especially in counties where injection drug abuse is highest.

"Currently 10 states exempt some or all syringes from their drug paraphernalia laws...While it is not exactly known if drug abuse will decrease as a result of needle decriminalization, nationally, most law enforcement officers surveyed have been in favor of decriminalization."

There is no doubt that prisons and jails in America are overcrowded and are an enormous financial burden to the country. According to the Bureau of Justice Statistics, America incarcerates more people (24%) than any other country in the world however the US makes up less than 5% of the world's population. Of those incarcerated, approximately half have substance abuse problems often resulting in drug related criminal activity. [1]

In Kentucky, incarceration rates exceed those of other states in virtually every demographic: Whites (at a rate of 561 per 100,000) have higher incarceration rates than 40 other states; the rate for African Americans (2,793 per 100,000) is higher than 33 other states; and Hispanics (757 per 100,000) exceed 23 other states in rates of incarceration. **Kentucky also exceeds the rate imprisoned nationally in every category.** [2]

Priority One: Needle Decriminalization

Currently 10 states exempt some or all syringes from their drug paraphernalia laws. In North Carolina House Bill 850, which partially decriminalizes needles, passed in the House and the Senate in June 2013 primarily due to diligent campaign efforts by the North Carolina Harm Reduction Coalition. While it is not exactly known if drug abuse will decrease as a result of needle decriminalization, nationally most law enforcement officers surveyed have been in favor of decriminalization. In New Mexico, needle-sticks to law enforcement have declined by 66% since implementing partial

decriminalization[3]. Decriminalization of needles would allow people carrying syringes to avoid arrest if they are honest and upfront with police about carrying such paraphernalia prior to search. Additionally, decriminalization could cut down on the number of needles thrown on the ground prior to police apprehension, thus preventing community danger.

According to the Kentucky Department of Corrections, the average cost to incarcerate an individual in a state facility in FY2012 was $22,011 annually or $60.14 per day. The average cost for an individual at a halfway house and/or a substance abuse facility was approximately ½ the cost of incarceration ($11,698 annually/$31.96 per day).[4] Drug Court currently operates in 115 Kentucky counties and has been proven effective over lengthy jail or prison terms for lower level crimes. The cost for probation, diversion, and/or substance abuse programs are significantly lower when compared to incarceration. Recidivism rates are much lower for those completing drug court. Those participating in drug court are much more likely to obtain a long term job and pay child support.[5]

As of 2010, drug related deaths have annually exceeded the number of motor vehicle deaths in Kentucky. In 2012, there were 732 drug related deaths in Kentucky. Of those, 143 involved heroin. The two geographic areas where the majority of these 143 deaths occurred were Louisville (72) and Northern Kentucky (61).[6] Between 2008-2011, three counties in Northern Kentucky (Boone, Kenton, & Campbell) accounted for nearly 60% of all of Kentucky's heroin prosecutions.[7] Heroin abuse has negatively impacted the entire Commonwealth in recent years. The crackdown on prescription pain pills and the fact that heroin is readily available and relatively cheap has fueled this statewide epidemic. Heroin samples collected by the Kentucky State Police lab have increased by a staggering 211% from 2010 to 2012 (433 vs. 1,349).[8] Demographically, current heroin abuse is primarily impacting white males and females between the ages of 20 to 40. Lower education and poorer economic status do not appear to be factors that further define this group of abusers.

According to the National Survey on Drug Use

Opportunity One: Needle Decriminalization

and Health, data collected from 2006 through 2008 found that an annual average of 425,000 persons 12 and older injected drugs within the past survey year. Thirteen percent (55,250) of those individuals reported that they used a shared needle within the past month of using.[9] Between 50%-80% of all Intravenous Drug Users (IDUs) will contract Hepatitis C within 5 years of abusing injection drugs. The CDC estimates 3.2 million Americans to have Hepatitis C.[10] Approximately 16% of all HIV cases in the US are from injection drug use. The CDC estimates 1.2 million Americans have HIV/AIDS.[11] Clearly these are major public health problems that result in hundreds of lives lost and billions of dollars spent each year for medical treatment in the United States. Access to clean needles could tremendously change these statistics. Syringe Exchange Programs (SEP's) are an effective public health method to reduce new HIV/Hepatitis infections. SEPs protect law enforcement and first responders as well as communities at large from potential needle sticks. SEPs also provide vital substance abuse resources/services to those struggling with addiction. Numerous studies have shown SEP's don't increase crime or encourage more people to abuse drugs. In fact, cities with SEPs like Baltimore, Portland, and San Francisco saw crime rates reduced and program participants more likely to enter drug treatment. Approximately 211 SEP's are currently operating in the US and Puerto Rico.[12] Unfortunately in 2011 Congress reinstated a ban on use of federal funds to help support SEP's after lifting a 21 year ban in 2009. This ban has had a huge negative impact on the effect that SEP's have done in terms of reducing HIV/Hepatitis. In order to work towards an AIDS Free Generation as outlined in the National HIV/AIDS Strategy full financial support for SEP's is desperately needed.[13]

COST-BENEFIT ANALYSIS

- The average cost to incarcerate an individual in a state facility in FY2012 was $22,011 annually or $60.14 per day.
- The average cost for an individual at a halfway house and/or a substance abuse facility was approximately ½ the cost of incarceration ($11,698 annually/$31.96 per day).

In conclusion, KHPAC recommends implementing a statewide policy that decriminalizes the use of needles (please reference KRS 217.177, KRS 218A.500, and KRS 510). This would help law enforcement and first responders prevent needle sticks and potential exposure to HIV and Hepatitis especially with the increase in IDU in the Commonwealth. KHPAC also recommends that substance abuse treatment services be made readily available, including the use of Drug Court and diversion programs. While KHPAC commends Governor Beshear on his dedication and efforts to make Recovery Kentucky a reality, it would like to see an expansion of substance abuse services to reduce long waiting lists for treatment as well as additional funding to assist those who are uninsured and cannot afford treatment. **Finally, KHPAC recommends supporting efforts**

Opportunity One: Needle Decriminalization

to reverse the national ban on the use of federal funds for Syringe Exchange Programs. While ideally KHPAC would like to see SEPs available throughout the Commonwealth, the group is aware of the controversial nature SEP's bring to the political arena. Lifting the ban on federal funding would help reduce the number of new HIV and Hepatitis cases in the US, promote public safety, and emphasize substance abuse services to those struggling with addiction.

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13. The White House Office of National AIDS Policy, "National HIV/AIDS Strategy for the United States," pgs 6 & 16-17, July 2010.

Priority Two:

HIV Testing for Pregnant Women

KHPAC RECOMMENDS:

- Kentucky should establish a legal mandate requiring that all pregnant women receiving care in the Commonwealth be offered HIV testing and counseling, regardless of perceived risk, as part of routine pre-natal care.

Mother-to-child HIV transmission is at an all time low, thanks largely to advances in medical treatment.

Under normal circumstances, with no other interventions, an HIV+ mother has a 1 in 4 chance of transmitting the virus to her child.[1]

In 1994, the National Institutes of Health demonstrated that the use of antiretroviral therapy in a three-part regimen during antenatal, intrapartum, and newborn periods reduced perinatal HIV transmission rates from roughly 22% to 8%.[2] Transmission rates are further reduced to 2% when antiretroviral treatment is used in conjunction with elective cesarean delivery[3]. As a result of these measures the number of prenatal AIDS cases in the US dropped 67% in the five years following the implementation of these initiatives in 1992. [4]

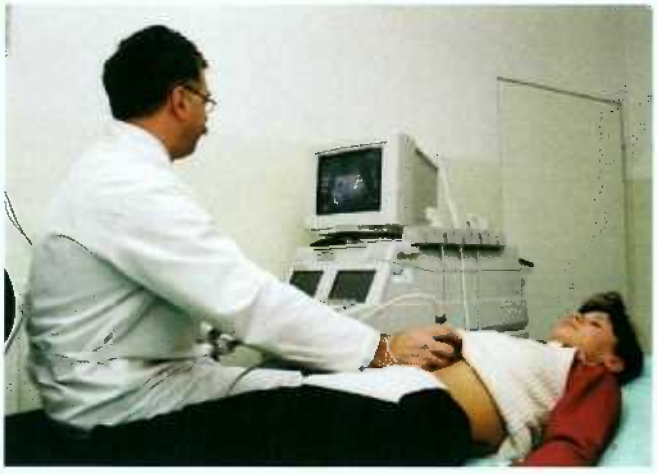
Additionally, when HIV exposure is detected in newborns, infection rates are reduced to 9% if antiretroviral treatment is administered during the first 48 hours of life and reduced to 18% if treatment begins on day 3 of life or later. [5]

In 2006 the Centers for Disease Control and Prevention (CDC) recommended the following guidelines for pregnant women[6]:

Priority Two: HIV Testing for Pregnant Women

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.
- Rapid HIV testing during labor and delivery for women who did not have a prenatal test result.

KHPAC now recommends opt-out screening of all pregnant women in accordance with the CDC's recommendation. Opt-out screening means a woman will receive an HIV test unless she specifically declines. This is a change from KHPAC's previous recommendation of opt-in testing, which would require explicit, informed consent. While KHPAC asserts that informed consent and voluntary testing are critical ethical concerns, opt-out testing is the most desirable option in order to achieve the goals of the National HIV/AIDS Strategy.[7]



As of January 2011, 46 states and jurisdictions, including Washington, DC, were coded as compatible with the 2006 CDC recommendations for consent and counseling.[8] **To date, Kentucky has taken no action to mandate the offering of HIV testing to pregnant women as part of routine care.**

COST-BENEFIT ANALYSIS

- Screening of pregnant women as part of routine pre-natal care has been projected to save more than $3.69 million dollars and prevent 64.6 cases of pediatric HIV infection for every 100,000 pregnant women screened.[9]
- Average lifetime medical costs for a child born with HIV is over $1.8 million.[10] Average lifetime medical costs for an adult diagnosed with HIV is over $385,000.[11]

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Priority Two: HIV Testing for Pregnant Women

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Priority Three:

Comprehensive Sexuality Education

KHPAC RECOMMENDS:

- Kentucky should require comprehensive sexuality education be provided in all public middle and high schools in Kentucky, as identified in the Program of Studies (2006) using evidence-based resources.
- Kentucky should also develop a process to ensure all middle and high school students receive this education as required by law.
- Kentucky should continue to access funding under the Personal Responsibility Education Program (PREP), which provides federal dollars for comprehensive sexuality education programs and has no state matching requirement.

The Kentucky Core Academic Standards specifically reference the need to prepare students to lead healthy lives.

Goal 3.2 states that Kentucky's academic programs will be measured on their ability to help "students demonstrate the ability to maintain a healthy lifestyle." This is important to Kentucky's youth and young adult population because research tells us that **in 2010, 12,000 new HIV cases were reported among youth ages 13-24**. The 2009 Kentucky Youth Risk Behavior Survey completed by the Centers for Disease Control and Prevention (CDC) indicates that, by the end of high school, approximately 50% of Kentucky high school students have had sexual intercourse. These statistics highlight the critical imperative to ensure that our schools consistently and accurately teach students what they need to know to make well-informed decisions to reduce the risk of unintended pregnancy or contracting HIV or other STIs.

The 2009 Kentucky Youth Risk Behavior Survey further indicates that many school districts in Kentucky report they are providing suitable health education. However, not all school districts provide this education, and those that do, deliver it with varying levels of success. For example, only 78% of Kentucky school

Priority Three: Comprehensive Sexuality Education

districts have a health education curriculum that addresses all eight national standards for health education. In the required course, only 60% taught the four key topics related to condom use. And while 91% of Kentucky school districts report that they taught eight key pregnancy, HIV, or other STI prevention topics in a required course, **more than 15% of Kentucky high school students indicate that they were not taught about HIV and AIDS in school.**[1]

Kentucky school districts also are missing a key opportunity to engage parents in this effort. Research has shown that youth whose peers engage in high-risk behaviors are more likely to develop similar behaviors, but that parental engagement can buffer these negative influences as adolescents age.[2] Unfortunately, only 39% of Kentucky school districts provided parents and families health information to increase parent and family knowledge of HIV prevention, STI prevention, or teen pregnancy prevention. Support for comprehensive sex education has a strong professional grounding – many American education, health, and medical professional associations have formally endorsed school-based comprehensive sex education, including the:

- American Association of School Administrators;
- American Medical Association;
- American Nurses Association;
- American Psychiatric Association;
- American Psychological Association;
- American Public Health Association;
- American School Health Association;
- National School Boards Association; and
- Society for Adolescent Medicine.

The contradiction between the support for comprehensive sexuality education among the populace and the lack of compliance in Kentucky school districts with the legal requirement to provide such education is puzzling. It has been suggested that school district leadership personnel are reluctant to comply for fear of parental backlash. However, studies have shown that parents across all age groups and all education levels preferred comprehensive sex education over abstinence-only programs[3,4].

Selected Statistics from the *2009 Kentucky Youth Risk Behavior Study*	AGE		
	15 or younger	16 or 17	18 or older
Percentage of KENTUCKY HIGH SCHOOL STUDENTS who have ever had sexual intercourse:	34%	55%	63%
Percentage of KENTUCKY HIGH SCHOOL STUDENTS who had sexual intercourse for the first time before age 13 years:	8%	6%	5%
Percentage of KENTUCKY HIGH SCHOOL STUDENTS who had sexual intercourse with four or more people during their life:	8%	13%	24%
Among KENTUCKY HIGH SCHOOL STUDENTS who had sexual intercourse during the past three months, the percentage who did not use a condom during last sexual intercourse:	34%	40%	Unknown

Priority Three: Comprehensive Sexuality Education

One study found no significant difference in such preference even between those who identified themselves as evangelical Christians and those who did not. The same study found only minimal differences in support between those who identified themselves as conservative, moderate, or liberal, with respondents of all ideological leanings being largely supportive of comprehensive sex education.[5]

While HIV is no longer a certain "death sentence," it is a "life sentence." There is no cure, and the medications taken to control the disease can severely impact an infected person's quality of life as well as their ability to be economically self-sufficient.

Youth and young adults who are more oriented to the "here and now" may have a limited capacity to understand or may place minimal value on long-term outcomes of risky sexual behaviors[6].

For this reason, **KHPAC recommends that comprehensive sexuality education be provided in all public middle and high schools in Kentucky, as identified in the Program of Studies (2006) using evidence-based resources.**

Comprehensive sexuality education would include developmentally appropriate, medically accurate information on the following topics:

- human development;
- decision-making;
- peer pressure;
- goal setting;
- conflict resolution;
- abstinence;
- contraception;
- healthy relationships; and
- disease prevention.

This recommendation is consistent with Kentucky's current curriculum standards (704KAR 3:303).

Because it is important that all Kentucky students consistently receive comprehensive sexuality education no matter in which Kentucky school district they are enrolled, **KHPAC also recommends that a process be developed to ensure all middle and high school students receive this education**, including students in special education classrooms. This process should be included in each district's

Priority Three: Comprehensive Sexuality Education

Comprehensive School Improvement Plan. **KHPAC also recommends that Kentucky continue to access funding under the Personal Responsibility Education Program (PREP)**, which **provides federal dollars** for comprehensive sexuality education programs and has **no state matching requirement**.

The Personal Responsibility Education Program is designed to meet the needs of today's high school aged youth by providing necessary and accurate information on the importance of healthy, responsible sexuality. PREP programs promote abstinence as the most effective and safest way to prevent unintended pregnancy and STIs. The curriculum also addresses reproductive anatomy, contraception, STIs, responsible sexual decision making, and healthy relationships. Teens who receive sex education that includes both the importance of waiting to have sex (abstinence) and complete, accurate information about contraception are more likely than those who receive abstinence-only-until-marriage messages to delay sexual activity.

COST-BENEFIT ANALYSIS

- The Personal Responsibility Education Program, or PREP, brings a preferred program to Kentucky, which is funded with federal dollars and requires NO state matching funds whereas the Title V Abstinence-Only program requires the state to provide $3 for every $4 dollars of federal funding.

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